Please furnish the following information about your patient to enable us to process your request for the use of Regranex Gel.

1. Name_____
2. Public Aid ID Number_____
3. Date of Birth_____
4. Verify patient is being treated for a diabetic neuropathic ulcer of the lower extremity_____
5. What is the size and location of the ulcer being treated?
   _____
6. Is the blood flow to the area being treated adequate to insure that healing will occur? (Regranex will be ineffective if there is no pulse or blood flow to the area.)_____
7. What previous treatments used for this patient were unsuccessful?
8. Has the wound bed been debrided, and is it clean?_____
9. Is there any infection present in the area being treated?_____
10. If yes, is there any discharge from the area being treated?_____
11. Has the patient or the patient's caregiver been trained by a member of your staff in the correct methods of measurement and application of this medication?_____

Please fax this information to me at 217-524-7264. Don't forget to provide your signature along with this information. The request for prior approval for the use of Regranex will be placed in a hold file until we receive this information. No decision will be made until then.

Physician's Signature_____
DEA Number or License Number _____
Physician's Telephone Number_____
Date _____

Gloria Mizer, R.Ph.
Consultant Pharmacist